City of Seattle

RETURN TO WORK / TIME LOSS
Certification

Dear Physician,

The City of Seattle believes it is in the best interest of both employees and the City for injured workers to remain on the job in their current position, or in a modified duty job.

We currently have modified duty positions to accommodate most physical limitations you might specify.

Please take a moment to complete this form and let us know the activity level permitted or restrictions needed for us to accommodate our employee.

EMPLOYEE'S NAME (PLEASE PRINT OR TYPE)	DEPARTMENT/DIVISION	JOB TITLE/ASSIGNMENT	DATE OF INJURY

PHYSICIAN'S FINDINGS & RECOMMENDATIONS

DIAGNOSIS: _____

Diagnosis ☐ is / ☐ is not directly a result of an industrial injury.

OBJECTIVE FINDINGS: _____

Is there permanent impairment? ☐ Yes ☐ No ☐ Undetermined

☐ Worker does not require further treatment.

☐ Worker requires the following treatment(s): _____

Follow-up Appointment Date: _____ With: _____

WORK STATUS *(Check appropriate boxes)***:**

☐ Full Duty ☐ Immediately On: _____

☐ Modified duty ☐ Immediately On: _____ (Please indicate work capabilities below)

☐ Temporarily disabled. Estimated return date: _____

WORK CAPABILITIES:

1. In an 8 hour work day worker may:
   - a. Stand/Walk ☐ None ☐ 1-4 hours ☐ 4-8 hours
   - b. Sit ☐ None ☐ 1-4 hours ☐ 4-8 hours
   - c. Drive ☐ None ☐ 1-4 hours ☐ 4-8 hours

2. Worker may use hands for repetitive:
   - ☐ Single Grasping ☐ Pushing and Pulling
   - ☐ Fine Manipulation

3. Worker may use feet for repetitive movements as in operating foot controls:
   ☐ Yes ☐ No

4. Worker is able to:

	Frequently	Occasionally	Not at all
a. Lift	☐ ____#	☐ ____#	☐ ____#
b. Bend	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Crouch	☐	☐	☐
f. Reach Overhead	☐	☐	☐
g. Crawl	☐	☐	☐
h. Kneel	☐	☐	☐

OTHER INSTRUCTIONS:

_____

_____

_____

Type/Print Licensed Physician's Name	Phone Number	Signature of Attending Licensed Physician**:**	Date:

Employees are required to return this completed form to their supervisor immediately following medical treatment.

Workers' compensation time loss benefits will end when your physician releases you to any modified work
Contact your employer immediately when your physician releases you to modified duty.

Employee's Signature	**Date**	**Supervisor's Signature**	**Date**

Supervisor, is temporary modified duty available? ☐ **Yes** ☐ **No** **Date available** _____ **Date started**_____